**COLINTON SURGERY**

Patient Consent Form

For another person to access their medical records

|  |
| --- |
| **Patient Details****(The person whose records another individual(s) is to be given access to)** |
| Surname |  |
| First Name |  |
| Date of Birth |  |
| Address |  |
| Telephone Number |  |

|  |
| --- |
| **Details of person the above patient wishes to give access to my medical records** |
| Full Name |  |
| Address |  |
| Telephone Number |  |
| Relationship |  |

|  |
| --- |
| **Please detail below if the above access is to be limited in any way (e.g only for test results, making or cancelling appointments, prescription requests, communication with a GP or for a specified time period only)** |
|  |

|  |
| --- |
| **I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records as detailed above** |
| Signature |  |
| Date  |  |

Admin use = docman to workflow administrators and code #9q